UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CATHRYN L. ALONSO, *Plaintiff*,	§	
	§	
vs.	§	CIVIL ACTION H-04-0562
	§	
STANDARD INSURANCE CO., *et al.*, *Defendants*.	§	

REVISED MEMORANDUM AND RECOMMENDATION

This is an ERISA action brought by plaintiff Cathryn L. Alonso, Independent Administratrix of the estate of Nita Ferguson Brownfield, for supplemental life insurance benefits. Before the court are motions for summary judgment by defendant Standard Insurance Co. (Dkt. 22), and defendants Convergys Corporation and Convergys Management Group Inc. (Convergys) (Dkt. 24). These motions have been referred to this court for recommendation. For the reasons explained below,[1] the court recommends that both motions be granted.

Background

The following facts are not disputed: Nita Brownfield's husband, James Brownfield, was covered under a group life insurance policy issued by Standard to his employer Convergys. Brownfield was hired by Convergys on August 30, 1999,

[1] The court issues this revised memorandum after considering plaintiff's objections and Standard's responses to the original Memorandum and Recommendation (Dkt. Nos. 43, 44). The ultimate recommendations remain unchanged.

and became eligible for basic life insurance benefits under the policy October 1, 1999. Beyond the basic life insurance, the policy also provided "Additional Life Benefits" of up to five times annual earnings and "Dependent Life Insurance" of up to $100,000.00. Brownfield did not select these forms of supplemental insurance during his initial 31 day period of eligibility.

The 1999 benefits enrollment form that Brownfield completed during this period stated that "Any amounts elected ... after first enrollment must go through underwriting and be approved by the carrier before additional coverage goes into force." The policy also states that after the initial enrollment period, evidence of insurability[2] is to be provided before these coverages take effect. Moreover, the policy allocates discretion to Standard to determine eligibility for insurance, entitlement to benefits, and the amount of benefits payable.

On November 8, 2000, during an open enrollment period, Brownfield completed an enrollment work sheet for the 2001 benefit year selecting additional life insurance of five times his annual salary, and dependent life insurance in the amount of $25,000. On the 2002 work sheet, Brownfield wrote "same" next to additional life insurance for three times his annual salary, and "same" next to dependent life

[2] The policy defines "Evidence of Insurability" as meaning that an applicant must (1) "Complete and sign our medical history statement;" (2) "Sign our form authorizing us to obtain information about the applicant's health;" (3) "Undergo a physical examination, if required by us, which may include blood testing; and" (4) "Provide any additional information about the applicant's insurability that we may reasonably require." Dkt. 22, Ex. 1, at 3-4.

insurance of $25,000. Both the 2001 and 2002 work sheets contained a statement above the signature line that "I understand that if I decide at a later date that I want any of the coverage ... I now decline, I ... may have to show Evidence of Insurability."

Premiums for the supplemental coverages were deducted from Brownfield's pay for fourteen months, despite the fact that he did not submit the evidence of insurability, and despite the fact that Standard did not expressly approve the additional coverage. These premiums were mistakenly deducted by Convergys under a "summary-billing" procedure, whereby Convergys would collect premiums from its employees covered by the policy and forward them essentially "in bulk" to Standard. Standard was not advised of the individual identities of those covered, or their respective coverages.

James Brownfield died on March 6, 2002, and his wife Nita died a few weeks later on March 29, 2002. The estate of Nita Brownfield submitted a claim for benefits under the policy. While Standard paid the basic life insurance, it denied the claims for additional life insurance and dependent life insurance, asserting that James Brownfield did not submit the evidence of insurability forms, and it did not approve the supplemental coverages. The estate appealed this decision May 9, 2003, and Standard rejected the claim again July 9, 2003. Standard attempted to refund the $311.65 of premiums that were deducted for the supplemental coverages, but the

estate has not cashed the refund checks. Standard conducted additional reviews of the claim for supplemental coverages, and denied them once more on September 9 and 10, 2003.

The estate has filed suit under ERISA, and has brought claims for breach of contract, breach of fiduciary duty, waiver, and estoppel. *See* Pl.'s First Am. Compl. ¶¶ 45-75. The estate argues that since Convergys collected, and Standard accepted, premiums for those benefits for fourteen months, they are estopped from denying coverage based on the lack of evidence of insurability and have waived any such defense to coverage. The estate is seeking benefits of $110,000 for the additional life insurance coverage for James Brownfield, and $25,000 of dependent life insurance benefit covering Nita Brownfield. *See id.*, ¶¶ 37, 41-43, 47-49, 78.

Analysis

I. Standards of Review

Summary judgment is appropriate if no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law. FED. R. CIV. P. 56(c). The party moving for summary judgment must demonstrate that there are no genuine issues of material fact. *Provident Life & Accident Ins. Co. v. Goel*, 274 F.3d 984, 991 (5th Cir. 2001). In responding to a properly supported summary judgment motion, the non-movant cannot merely rely on its pleadings, but must present specific and

supported material facts, of significant probative value, to preclude summary judgment. *See Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *Caboni v. Gen. Motors Corp.*, 278 F.3d 448, 451 (5th Cir. 2002). In determining whether a genuine issue of material fact exists, the court views the evidence and draws inferences in the light most favorable to the nonmoving party. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986).

Where an ERISA benefits plan provides that the plan administrator has discretionary authority to construe the terms of the plan, then the plan administrator's denial of benefits is reviewed only for abuse of discretion. *See MacLachlan v. ExxonMobil Corp.*, 350 F.3d 472, 478 (5th Cir. 2003); *Gosselink v. American Tel. & Tel., Inc.*, 272 F.3d 722, 726 (5th Cir. 2001). The court's review of the plan administrator's decision denying benefits need only assure that the administrator's decision fall somewhere on a continuum of reasonableness–even if on the low end. *See Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (*en banc*).

Because the policy gives full discretion to the administrator to construe its terms, the proper standard of review of the decision denying benefits is abuse of discretion,[3] using a two step analysis. *See Vercher v. Alexander & Alexander Inc.*,

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[3] Under the heading of "Allocation of Authority," the plan provides:

> Except for those functions which the Group Policy specifically reserves to the Policyowner, subject to Utah law (unless pre-empted by Erisa), we have full and

379 F.3d 222, 226 (5th Cir. 2004); *Gosselink*, 272 F.3d at 726. First, the court determines the legally correct interpretation of the plan, considering: (1) whether the administrator has given the plan a uniform construction; (2) whether the interpretation is consistent with a fair reading of the plan; and (3) any unanticipated costs resulting from different interpretations. *See Gosselink*, 272 F.3d at 726. The second factor is considered the most important. *Id.* at 727. If the administrator's construction is legally sound, then no abuse of discretion occurred and the inquiry ends. *Vercher*, 379 F.3d at 227.

If the court concludes the plan administrator's interpretation is legally incorrect, the court must then determine whether the administrator abused his

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> exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy. However, this provision will not restrict any right you may have to file a lawsuit if your claim for benefits is denied or ignored.
> Our authority includes, but is not limited to:
>
> 1. The right to resolve all matters when a review has been requested;
> 2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
> 3. The right to determine:
>   a. Eligibility for insurance;
>   b. Entitlement to benefits;
>   c. Amount of benefits payable;
>   d. Sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.
>
> Subject to the review procedures of the Group Policy, and subject to Utah law (unless pre-empted by Erisa), any decision we make in the exercise of our authority is conclusive and binding.

(Dkt. 24, Ex. 1, at 19).

discretion looking at three additional factors: (1) the internal consistency of the plan under the administrator's interpretation; (2) any relevant regulations promulgated by the appropriate administrative agencies; and (3) the factual background of the determination and any inferences of bad faith. *See Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 638 (5th Cir. 1992).

The existence of a conflict of interest is another factor to consider in determining whether a plan administrator abused its discretion. *See Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (*en banc*). Where there is a conflict of interest, this does not change the applicable standard, but does require the court to apply a sliding scale of deference. *MacLachlan v. ExxonMobil Corp.*, 350 F.3d 472, 478 (5th Cir. 2003). Less than full deference is accorded a denial of benefits by an administrator who is also an insurer of the plan, because such an administrator potentially benefits from every denied claim. *See Gooden v. Provident Life & Accident Ins. Co.*, 250 F.3d 329, 333 (5th Cir. 2001).

II. Proper Party Defendant

Before turning to the merits, it is appropriate to address the claim of Brownfield's former employer, Convergys, that it is not a proper defendant in this action. According to the estate, Convergys "acted in concert" with Standard by signing up applicants, calculating and collecting premiums, and then forwarding them

to Standard, and thus, Convergys is also liable for the decision denying benefits, even though Standard was the sole administrator in determining the payment of claims. Dkt. 27, at 7.

This argument is without merit. As a general rule, the proper party defendant in a suit for benefits under ERISA section 502(a)(1)(B) is the plan or the plan administrator. *See* 29 U.S.C. § 1132(d)(2) ("Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity..."); *see also Blum v. Spectrum Rest. Group Inc.*, 261 F. Supp. 2d 697, 708 (E.D. Tex. 2003) (citing cases); *Murphy v. Wal-Mart Assocs.' Group Health Plan*, 928 F. Supp. 700, 709-10 (E.D. Tex 1996); *Crawford v. Exxon Corp.*, 851 F. Supp. 242, 244 (M.D. La. 1994). An exception may apply if an ERISA plan is a self-administered, unfunded benefit plan, with no separate existence apart from the employer. *See Musmeci v. Schwegmann Giant Super Mkts., Inc.*, 332 F.3d 339, 349-50 (5th Cir. 2003); *Slaughter v. AT & T Info. Sys., Inc.,* 905 F.2d 92, 94 (5th Cir. 1990). That is not the case here. Standard was expressly given "full and exclusive authority" to administer the policy. Dkt. 24, Ex. 1, at 19. The plan unquestionably has a separate existence apart from the employer. Convergys, therefore, is not a proper defendant in this action, even assuming that it performed functions which assisted in the administration of the plan.

III. Plan Interpretation

Section 502(a) of ERISA authorizes a civil action by a plan participant "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). The estate claims Standard's denial of benefits was arbitrary and capricious. *See* Pl.'s First. Am. Compl., at ¶ 51. Standard denied the estate's claim on the grounds that the policy had two important preconditions that were not fulfilled: (1) Brownfield needed to submit "evidence of insurability,"[4] and (2) Standard needed to approve the supplemental coverage before it took effect.

Because the plan confers discretionary authority upon the administrator to construe the terms of the plan, the court reviews the denial of benefits for abuse of discretion, keeping in mind the potential conflict of interest of Standard as the insurer of the plan in denying the benefits. With regard to the additional life insurance, Standard's interpretation is consistent with a fair reading of the policy. The policy declares that evidence of insurability is required "[t]o become insured for Plan 2 Life Insurance in excess of the lesser of i) $500,000, and ii) 3 times your Annual Earnings, if you become a Member on or after January 1, 1999." Dkt. 22, Ex. 1, at 23. The original 1999 benefits enrollment form signed by Brownfield also states, "Any

[4] One provision provides that "Life Insurance subject to Evidence Of Insurability" and that "Evidence of Insurability is required if you apply more than 31 days after you become eligible." Dkt. 22, Ex. 1, at 17-18. Another states that "Evidence Of Insurability" is required "For late application for Voluntary insurance." Dkt. 22, Ex. 1, at 23.

amounts elected above this [three times annual pay] or after first enrollment must go through underwriting and be approved by the carrier before additional coverage goes into effect." Dkt. 22, Ex. 1, at 221.

The "Life Insurance and Income Protection Benefits" guides provided to Convergys employees during open enrollment periods also made clear that evidence of insurability would be required for the additional life insurance. These guides stated that "If you do not enroll yourself and/or your dependents for additional/dependent insurance the first time you are eligible, you will have to provide evidence of insurability which may include a physical examination." Dkt. 24, Ex. 3, at 40. They also provided that "If you wish to apply for amounts [of additional or supplemental insurance] greater than 3 times your annual salary or $500,000, whichever is less, you will be required to provide evidence of insurability. Please note, any amounts you apply for after your initial enrollment will require evidence of insurability." Dkt. 24, Ex. 3, at 41.

Brownfield applied for additional life insurance after his initial enrollment period. Thus, evidence of insurability was required under a fair reading of the policy, and Standard's decision denying the additional life insurance benefit was legally correct and not an abuse of discretion.

The terms of the policy also require evidence of insurability for dependent life insurance, at least in certain situations.[5] Here, Standard relies upon subparagraph (a), which requires evidence of insurability for "late application for Voluntary insurance." Dkt. 22, Ex. 1, at 23. The policy defines "Voluntary" to mean "you pay all or part of the premium for insurance", as opposed to an employer-paid premium. *Id.* at 3. Whether dependent life insurance is voluntary or employer-paid depends on how it is described in the "Coverages Features" section of the policy. *Id.* at 15. Here, the "Coverages Features" section expressly declares dependent life insurance to be "Voluntary." *Id.* at 23. Thus, the policy unambiguously requires evidence of insurability as a precondition for late dependent life insurance applications. It is undisputed that Brownfield's application for dependent life insurance was late,

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[5] The policy lists seven instances when evidence of insurability will be required:

> a. For late application for Voluntary insurance.
> b. For reinstatement if required.
> c. To become insured for Plan 2 Life Insurance in excess of the lesser of i) $500,000, and ii) 3 times your Annual Earnings, if you become a Member on or after January 1, 1999.
> d. To become insured for Plan 2 Life Insurance, if you become a Member before January 1, 1999. This requirement is waived on January 1, 1999 for amounts which do not exceed the lesser of i) $500,000, and ii) 3 times your Annual Earnings, if you apply between November 2, 1998 and December 31, 1998.
> e. To become insured for Dependents Life Insurance in excess of $25,000, if you become a Member on or after January 1, 1999.
> f. To become insured for Dependents Life Insurance if you become a Member before January 1, 1999. This requirement will not apply on January 1, 1999 to i) amounts on your Spouse which do not exceed $25,000, and ii) amounts for your Child, if you apply between November 2, 1998 and December 31, 1998.
> g. Any elective increase in Plan 2 Life Insurance or Dependents Life Insurance.

Dkt. 22, Ex. 1, at 23.

because he did not apply for it during the initial enrollment period. *Id.* at 226-29. Accordingly, Standard's enforcement of this precondition to coverage was proper.

The estate contends that use of the word "may" rather than "shall" on certain enrollment worksheets creates ambiguity regarding the evidence of insurability precondition to coverage. *See, e.g.,* Dkt. 22, Ex. 1, at 226 ("I understand that if I decide at a later date that I want any of the coverage for which I and my dependents are now eligible, but I now decline, I may have to wait for the next ANNUAL enrollment period and may have to show Evidence of Insurability") (underscoring supplied). As Standard points out, this language is not confined to the specific context of dependent life, but instead addresses all types of coverages, both employer-paid and voluntary, and all dates of enrollment, both initial and late. In this context, the single word "may" does not create ambiguity regarding the evidence of insurability precondition for dependent life coverage.

For these reasons, Standard interpreted the policy in a legally-correct fashion, and did not abuse its discretion in denying the claims.

IV. Waiver

The estate's main argument is that Standard has waived its right to insist on the evidence of insurability precondition by accepting the supplemental premiums which Covergys had deducted from Brownfield's paycheck for fourteen months.

As the estate correctly observes, the Fifth Circuit has applied the doctrine of waiver in actions to recover insurance benefits under ERISA plans. In *Pitts v. American Sec. Life Ins. Co.,* 931 F.2d 351 (5th Cir. 1991), the court ruled that an insurer waived a policy defense to ERISA liability by accepting premiums and paying medical benefits after learning that the policy condition (i.e. a minimum of ten employees) had not been met. And in *Rhorer v. Raytheon Eng'rs & Constructors, Inc.*, 181 F.3d 634 (5th Cir. 1999), the court found that the plan administrator (who was also the employer) may have waived its right to enforce the policy's active work requirement, by enrolling Rhorer in optional life insurance and accepting his premiums for over a year despite its actual knowledge that Rhorer was no longer actively working.[6] This circuit has also applied the federal common law of waiver in other ERISA contexts. *See, e.g., Guardian Life Ins. Co. v. Finch,* 395 F.3d 238, 240-44 (5th Cir. 2004) (waiver doctrine applied to determination of beneficiary status under ERISA plan); *Brandon v. Travelers Ins. Co.,* 18 F.3d 1321, 1325-27 (5th Cir. 1994) (same).

[6] The Fifth Circuit has not specified precisely how the waiver analysis fits into the *Wildbur* two-step abuse of discretion review of ERISA benefit denials. *Pitts* did not discuss the standard of review issue, and the *Rhorer* court expressly found that the administrator had adopted a legally incorrect interpretation of the plan. Thus, it is unclear whether a waiver claim remains viable after a court finding that the administrator has not abused its discretion in denying the claim. For the purposes of this decision, the court will assume *arguendo* that a waiver claim may survive despite such a finding.

Waiver is the intentional or voluntary relinquishment of a known right. *Rhorer,* 181 F.3d at 645; *Pitts,* 931 F.2d at 357. In the context of determining ERISA beneficiary status, a waiver is valid if it is "explicit, voluntary, and made in good faith." *Brandon,* 18 F.3d at 1327. However, an implicit waiver by conduct was recognized in both *Pitts* and *Rhorer,* where the plan administrator accepted premium payments despite actual knowledge that policy requirements were not satisfied.

Standard counters that, unlike *Pitts* or *Rhorer,* there is no evidence here of intentional or knowing conduct to support a waiver claim.[7] Standard did accept fourteen months of premium payments which Convergys had mistakenly deducted from Brownfield's paycheck, but these payments were consolidated with premium deductions from all other covered employees during the same time period. Under the arrangement between Standard and Convergys, it was the responsibility of Convergys to enroll covered employees, to calculate and deduct the appropriate premiums from the employee's paycheck, and to forward those premiums to Standard each month. Under this "summary billing" procedure, Standard was not put on notice which particular employees had paid premiums for which coverages. Moreover, the clerical

[7] Standard also contends, relying on general principles of insurance law, that a waiver cannot be used to create or expand coverage where none would otherwise exist under an ERISA plan. *See,. e.g., Lauder v. First UNUM Life Ins. Co.,* 284 F.3d 375, 381 (2d Cir. 2002). The Fifth Circuit has not addressed this issue in the ERISA context, although in a recent case under Texas insurance law the court observed that a condition precedent to an insurance contract is "susceptible of waiver." *Monumental Life Ins v. Hayes-Jenkins*, 403 F.3d 304, 314 (5th Cir. 2005). Because Standard's motion is persuasive on other grounds, it is unnecessary to reach this issue.

error exclusion of the policy exonerated Standard from any responsibility for mistakes such as erroneous premium deductions. Presumably, by handling such clerical tasks in-house, Convergys was able to reduce the cost of providing this benefit to its employees.

The summary billing practice used by Standard fundamentally distinguishes this case from *Pitts* and *Rhorer*. The insurer in *Pitts* accepted premiums and paid health insurance claims without a reservation of rights **after** learning that the policy conditions had been violated. *Pitts*, 931 F.2d at 357 ("American Security accepted insurance premiums from United Plumbing for five months after learning beyond all doubt that Pitts was the only employee remaining on the policy") (emphasis added). In *Rhorer,* the administrator of a self-insured plan agreed to enroll the insured for coverage even though, as his employer, it had actual knowledge that he worked from his home and not in the office in violation of the active work requirement in the plan. *Rhorer*, 181 F.3d at 645.

Unlike the plan administrator in those cases, Standard had no knowledge that the claimant had failed to satisfy a policy condition, and so Standard's acceptance of premiums deducted from Brownfield's paycheck cannot fairly be characterized as an intentional or knowing relinquishment of a policy defense. *See Blum v. Spectrum Rest. Group, Inc.,* 261 F. Supp. 2d 697, 718 (E.D. Tex. 2003) (mistaken paycheck

deduction by employer held not to support intentional waiver of policy condition by insurer). Another distinguishing factor here is the clerical error exclusion in the policy. The calculation of paycheck premium deductions is essentially a clerical function performed by the employer. The clerical error exclusion, a standard clause in insurance policies, is further confirmation that Standard did not intend to waive policy requirements based on an employer's clerical error in calculating and deducting policy premiums.

At the hearing, counsel for the estate argued that the summary billing system itself constitutes a waiver of policy defenses, because Standard "should have known" that such a system would generate this very type of mistake and would insulate Standard from learning about the improper deduction until after a claim was filed. This argument misses the mark. Mere negligence is not sufficient to establish waiver; there must be an intentional and purposeful surrender of a known right. Nothing in the record indicates that Standard intentionally designed the summary billing system in order to profit from premium over-deductions by the employer. Counsel for the estate conceded that there was no evidence of similar mistakes affecting other plan participants. Absent some evidence that Standard's lack of awareness of paycheck deduction errors was the product of wilful ignorance, there is no basis to conclude

that Standard's summary billing procedure in itself effected a waiver of the policy requirements.

V. Estoppel

Whether an estoppel claim may even be asserted in the context of ERISA in the Fifth Circuit on the basis of a written misrepresentation is not certain,[8] although it is rather doubtful. *See McCall v. Burlington N./Santa Fe Co.*, 237 F.3d 506, 513 (5th Cir. 2000); *Weir v. Fed. Asset Disposition Ass'n*, 123 F.3d 281, 290 (5th Cir. 1997). If such a claim is cognizable, then to recover benefits under an equitable estoppel theory, an ERISA beneficiary must establish: (1) a material misrepresentation; (2) reasonable and detrimental reliance upon the representation; and (3) extraordinary circumstances. *McCall*, 237 F.3d at 513; *Weir*, 123 F.3d at 290.

The estate has failed to raise a genuine issue of material fact with respect to any of these elements. There was no material misrepresentation with respect to the additional life insurance. The open enrollment guides provided in 2000, 2001, and 2002, stated that "If you wish to apply for amounts greater than 3 times your annual salary or $500,000, whichever is less, you will be required to provide evidence of

[8] It is clear that oral misrepresentations cannot give rise to an estoppel claim under ERISA. *See, e.g., Rodrigue v. W. & S. Life Ins. Co.*, 948 F.2d 969, 972 (5th Cir. 1991) (precluding an ERISA claimant from arguing that an ERISA plan provider was estopped from denying coverage based on oral modifications to the plan); *Degan v. Ford Motor Co.*, 869 F.2d 889, 895 (5th Cir. 1989) (concluding that the court was not free to fashion federal common law that recognized estoppel-based arguments for oral modifications to ERISA plans); *Cefalu v. B.F. Goodrich Co.*, 871 F.2d 1290, 1297 (5th Cir. 1989) (holding that an oral agreement cannot be the basis of a cause of action under ERISA).

insurability." Dkt. 24, Ex. 3, at 41, Ex. 5, at 50, Ex. 7, at 149. Nor was there ever any representation that evidence of insurability would not be required. Moreover, the 1999 policy stated: "Evidence of Insurability is required if you apply more than 31 days after you become eligble." Dkt. 22, Ex. 1, at 17. Brownfield applied for the supplemental coverages in 2000, well past the 31 days after he became eligible.

Finally, the policy explicitly required approval by Standard before the supplemental coverages would take effect. The 1999 benefits enrollment form filled out by Brownfield when he was hired declared that any supplemental coverages elected after the first enrollment "must go through underwriting and be approved by the carrier before additional coverage goes into force." Dkt. 22, Ex. 1, at 221.

This clear language in the documents compels the conclusion that there could not have been reasonable and detrimental reliance on the part of Brownfield. *See Weir v. Fed. Asset Disposition Ass'n*, 123 F.3d 281, 290 (5th Cir. 1997) (where a plan participant is in possession of a written document notifying her of the conditional nature of benefits, reliance on representations to the contrary cannot be reasonable). Thus, even if an estoppel theory were cognizable in the Fifth Circuit, the estate cannot establish such a claim.

VI. Other Claims

A. Breach of Fiduciary Duty

The estate's claim for breach of fiduciary duty should be also be dismissed. An ERISA plaintiff may bring a private action for breach of fiduciary duty only when no other remedy is available under 29 U.S.C. § 1132. *See Rhorer v. Raytheon Eng'rs & Constructors, Inc.*, 181 F.3d 634, 639 (5th Cir. 1999). However, where a plaintiff's predominant cause of action is to recover plan benefits under 29 U.S.C. § 1132(a)(1)(B),[9] she may not simultaneously maintain a claim for breach of fiduciary duty. *See Rhorer*, 181 F.3d at 639; *see also Tolson v. Avondale Indus., Inc.*, 141 F.3d 604, 610 (5th Cir. 1998) (where plaintiff has adequate relief available for the alleged improper denial of benefits through his right to sue under section 1132(a)(1), relief through the application of section 1132(a)(3)[10] would be inappropriate). Here the estate's predominant cause of action is to recover benefits pursuant to 29 U.S.C. § 1132(a)(1)(B), as the estate is seeking to enforce its purported right to benefits of $110,000 for the five times salary of coverage for James Brownfield, and a $25,000 life insurance benefit for Nita Brownfield. *See* Pl.'s First Am. Compl., ¶¶ 37, 41-43,

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[9] 29 U.S.C. § 1132(a)(1)(B) provides that "A civil action may be brought– (1) by a participant or beneficiary–... (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."

[10] 29 U.S.C. § 1132(a)(2) allows a beneficiary to bring a standard breach of fiduciary duty suit for the benefit of the subject plan. *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140-44 (1985).

47-49, 78. Thus, Standard and Convergys are entitled to summary judgment on the claims against them for breach of fiduciary duty. Indeed, the estate presents no factual argument and cites no legal authority that its claim for breach of fiduciary duty presents a genuine issue of material fact for trial.

B. Breach of Contract

The estate further argues that the defendants breached their contract by refusing to pay the supplemental coverages. *See* Pl.'s First Am. Compl., at ¶ 59. A suit by a beneficiary to recover benefits from a covered plan falls directly under section 502(a)(1)(B) of ERISA,[11] which provides an exclusive federal cause of action for resolution of such disputes. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62-63 (1987); *see also Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54-56 (1987) (any state law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted). To the extent that the estate's breach of contract claim seeks benefits outside of, or in addition to, the exclusive remedies provided by section 502(a) of ERISA, the claim is preempted.

[11] 29 U.S.C. § 1132(a)(1)(B).

Conclusion

For these reasons, the court recommends that summary judgment be entered in favor of Standard Insurance Company and Convergys on all of the estate's claims. The parties have ten days to file written objections to this Memorandum and Recommendation. *See* FED. R. CIV. P. 72.

Signed on May 27, 2005, at Houston, Texas.

Stephen Wm Smith
United States Magistrate Judge